EVALUATION AND IMPROVEMENT OF THE QUALITY OF CARE AT A MUNICIPAL HOSPITAL—A CRITIQUE*

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OUR panel has been asked to be practical and critical. Therefore, I shall emphasize the realities of our municipal hospital, where peer review[2, 5, 7, 8] is challenging and exciting. In our municipal hospital, however, peer review is also in triple jeopardy because of its size and complexity, because it is part of an academic medical center, and because it is a city hospital.

STRUCTURE

Among hospitals in the United States, Kings County Hospital is second only to Los Angeles County Hospital in size. Last year we had approximately 51,000 inpatient admissions and more than 1,000,000 ambulatory visits. In addition to our "umbrella" or coordinating quality-review committee, there are 18 specialized, quality-concerned, interdepartmental committees: ambulatory care, blood bank, by-laws, cancer, credentials, home care, house staff, infection, medical conference, medical records, mortality review, operating room, patient care, pharmacy and therapeutics, radioisotope, research, tissue, and utilization. There are also medical and community boards, and various nursing, social service, and other professional committees. We have the additional responsibility of peer review at the other hospital in our medical center: State University Hospital.

In an academic medical center the principle operating unit is the department. Because residents and attending physicians share responsibility for patients in Kings County Hospital, our reviews focus on de-

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partmental performance rather than on individual performance. Each of our 14 clinical departments has its own quality-assurance and educational activities. Formal, interdepartmental peer review[1, 4, 10] was not welcomed enthusiastically into this system as a complementary opportunity to improve education and performance. However this is changing slowly.

In a city hospital resources are an acute problem; improvements in structure and support for medical care either do not materialize or do so slowly.

Process[6]

Our committee is responsible for evaluating the care of all patients (including outpatients), making recommendations for improvements, and following up on these. Departments initially decide upon the criteria for audit, but the committee then has the opportunity to broaden or narrow the view. For example, psychologic counseling was introduced into a study of myocardial infarction by one of the psychiatrists on our committee. Our committee sets criteria for utilization which are enforced by utilization committees at each hospital. We thereby avoid having one committee basing its criteria on economy and another basing its criteria on quality. Follow-up on our recommendations is being incorporated into the process of utilization review so that ongoing reevaluation is possible without repeated audits.

Centralized responsibility for recommendations precludes having a committee member tell his chief how to run his department, adds objectivity, and prevents focusing too much attention on resource-expanding recommendations which stand little chance of being followed.

In addition to doing conventional audits[9, 10] in such areas as hypertension, asthma, the rehabilitation of amputees, and mortality on the psychiatric service, we have done some broad surveys on departmental quality-assurance activities and on the function and impact of some of the specialized, interdepartmental committees. We conducted these two surveys to get a better idea of how we might complement the quality-concerned efforts of departments and other committees and so that we could make recommendations and stimulate cross-fertilization. We are aware that some of our committees are not as effective as they might be.

Problems

The most important decision our committee has made is that we should not be just a medical audit committee, but a quality-improvement committee. With the approval of our medical board, we have made recommendations about major problems without conducting an audit.

One example of this is medical records. At our hospital the quality of the record is particularly related to the quality of care. Vast numbers of patients (many of whom do not speak English) and poor continuity and fragmentation of care into many subspecialized parts result in patients seeing a variety of unfamiliar doctors and vice versa. Without a record that effectively communicates, care is compromised.

Our outpatient and inpatient records are separate. At each admission the patient gets a new number which is different from the number he had as an outpatient. The problems with our records are so serious that subspecialities have developed their own records, and there are now 28 separate, uncoordinated, record-filing locations in Kings County Hospital.

Our committee recommended that a unit number and unit-record system be adopted. We organized a seminar on problem-oriented records and, after a thorough study of alternatives, recommended that problem-oriented records[15] be used throughout the center.

Perhaps we overemphasize the record. However, it is the main medium of review and it should reflect care given and communicate what is happening with the patient.[13, 14]

I imagine that many hospitals have similar, obvious, and major qualitative deficiencies. These must be addressed in one way or another if improvement is not to be compromised.

A major practical pitfall of any system of evaluation is that the excellence of evaluation often has little correlation with its effectiveness in improving care. The results of a baseline medical audit[12] devised by Dr. Mildred A. Morehead and her evaluation unit for the municipal hospitals in New York City exemplify this problem. The deficiencies found included insufficiently broad histories and omission of funduscopic, pelvic, and rectal examinations and pap smears. Several known problems were reaffirmed. The patient volume per doctor is too large for a comprehensive history, physical examination, or preventive care.

There also is insufficient equipment. For example, as long as eight doctors share one funduscope this will continue to result in omissions of funduscopy. Since the first study was done in 1972 none of the basic problems have been addressed. The only action taken was to repeat the audit two years later.

I do not mean to imply that the physicians themselves could not take some steps to improve care. But there remain the documented problems of insufficient staff which turns over rapidly because of difficult working conditions, low salaries, and poor morale.

Action and follow-up have not kept pace with our internal audits either. The future requirement by the Joint Commission on Accreditation of hospitals (JCAH) of one audit per month per department would put us even farther behind in translating recommendations into improvements and would reduce our evaluation activities to a bureaucratic paper shuffle. If good evaluation does not result in the improvement of care, then we must consider transferring some of the resources now devoted to evaluation to the care of patients rather than to increasing audits.

Another significant problem is the difficulty in molding all the uncoordinated outside requirements placed upon us by JCAH, Medicaid, Medicare, Professional Standards Review Organizations, state and city health departments, and the Health and Hospitals Corporation into an integrated, effective program for quality improvement.

Outcome?[3, 11]

To give credit where it is due, the mere launching of formal, interdepartmental peer review into the complex and doubting environment of our large, urban, academic medical center is a tribute to our medical board, our administration, and the members of our quality-review committee. At times our umbrella committee for quality review has felt as if its umbrella were upside down and collecting only renal runoff. We have learned that evaluation should be merely a means toward the improvement of the quality of care and, ultimately, toward health. Having been in existance only one year, the committee has had a discernible but small impact toward the improvement of the quality of our care. This makes us critically skeptical but not despairing of the probability of significant improvement without effective pressure from without. For this pressure to be wise and just it must be tempered

with reason and with recognition of the necessity for support through adequate resources if institutions can demonstrate that they are doing their qualitative best.

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REFERENCES

1. *Quality Assurance Program Manual.* Chicago, Amer. Hosp. Ass., 1974.
2. Barro, A. R.: *Survey and Evaluation of Approaches to Physician Performance Measurement.* Washington, D. C., Ass. Amer. Med. Colleges., 1972.
3. Bellin, L. E.: PSRO—quality control? or gimmickry? *Med. Care. 12:*1012, 1974.
4. *PSRO Program Manual.* Rockville, Md., Department of Health, Education, and Welfare, 1974, chap. 7.
5. Donabedian, A.: *A Guide to Medical Care Administration. Medical Care Appraisal—Quality and Utilization.* New York, Amer. Public Health Ass., 1969, vol. 2.
6. Donabedian, A: Promoting quality through evaluation of the process of patient care. *Med. Care 6:*196, 1968.
7. Donabedian, A.: Methods of Evaluating the Quality of Medical Care. In: *Presymptomatic Detection and Early Diagnosis,* Sharp, L. E. H. and Keen, H., editors. Baltimore, Williams and Wilkins, 1968, p. 121.
8. Donabedian, A.: Evaluating the quality of medical care. *Milbank Mem. Fund Quart. 44:*166, 1966.
9. Helbig, D. W., O'Hare, D., and Smith, N. W.: The care component score—A new system for evaluating quality of inpatient care. *Amer. J. Public Health. 62:*540, 1972.
10. *The PEP Primer.* Chicago, Joint Commission on Accreditation of Hospitals, 1974.
11. Lewis, C. E.: The state of the art of quality assessment—1973. *Med. Care 12:*799, 1974.
12. Morehead, M. A.: *Internal Audit Procedure Manual.* Bronx, N.Y., Evaluation Unit, Dept. Community Health, Albert Einstein College of Medicine, 1972.
13. Morehead, M.: The medical audit as an operational tool. *Amer. J. Public Health. 57:*1643, 1967.
14. Rosenfeld, L. S : Quality of medical care in hospitals. *Amer. J. Public Health. 47:*856, 1957.
15. Weed, L.: *Medical Records, Medical Education and Patient Care.* Cleveland, Case Western Reserve Press, 1969.